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FISCAL IMPACT STATEMENT

LS 6852
BILL NUMBER: HB 1572

NOTE PREPARED: Jan 22, 2009
BILL AMENDED:

SUBJECT: Medicaid Managed Care.

FIRST AUTHOR: Rep. Welch
FIRST SPONSOR:

BILL STATUS: Introduced

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill requires the Office of Medicaid Policy and Planning (OMPP) to expedite the review of an infant's placement and determine under certain circumstances that the infant is at a level of institutionalization that would qualify the infant for federal Supplemental Security Income.

This bill requires a managed care provider's contract or agreement under the Medicaid program to include a prescription drug program.

The bill requires each managed care organization that contracts with OMPP to provide services under the Medicaid program to: (1) have one uniform prescription drug formulary; (2) have one standard definition for specified terms; and (3) have one standard procedure for credentialing and claims processing.

The bill also requires payment for services under the Medicaid program in a hospital setting to be based on the individual's presenting symptoms and the services required to triage, diagnose, and treat the individual. The bill prohibits the denial of payment for services that are medically necessary solely because the provider did not obtain prior authorization in a timely manner.

Effective Date: Upon passage; July 1, 2009.

Explanation of State Expenditures: *Expedited Disability Determinations for Newborns:* The bill requires an expedited Supplemental Security Income (SSI) disability determination by the Medicaid Medical Review Team for infants that are in, or expected to be in, an intensive care setting for at least 30 days or that have an illness or condition that is included on the list of accelerated review diagnoses used by OMPP to indicate disability. An expedited review process for these children would not be expected to result in different

determinations, but rather it would change the timing of the financial consequences of the disability determination.

If the child is determined to be eligible for an SSI financial benefit, the SSI benefit payment is received sooner. The child's Medicaid eligibility for services may or may not be impacted. Over 50% of the births in Indiana are paid for by Medicaid. Infants born to mothers covered by Medicaid are automatically enrolled and remain eligible for the first year regardless of changes in the parent's income. The bill could speed the process of changing the child's Medicaid eligibility category from a Hoosier Healthwise managed care organization (MCO) to the fee-for-service program operated for the aged, blind, and disabled. This could reduce the MCOs' risk exposure faster while the Medicaid fee-for-service program would assume the cost sooner. The fiscal impact of this provision depends on the number of children that would fall into these circumstances and is mainly associated with the potential for a timing change in the related consequences of the disability determination.

SSI is available for children from birth to age 18; there is no minimum age requirement. A child is considered to be disabled for SSI purposes if the child is blind or has a physical or mental condition or conditions that can be medically proven and which result in marked and severe functional limitations. The condition must have lasted or be expected to last at least 12 months or end in death. Certain conditions are considered so disabling, SSI will make benefit payments immediately and continue for up to six months while the state is performing the disability review.

Emergency Department Provision: This bill would require OMPP and a Medicaid MCO to pay 100% of the Medicaid fee-for-service reimbursement rates for certain federally required screening exams provided by a physician in an emergency department whether or not those services meet the definition of what a prudent layperson would consider to be an emergency. Emergency department physicians who have executed MCO provider contracts would be excluded from this provision. The bill would result in increased costs to the state to the extent that any increased risk-based managed care costs would be passed through to the state in the annually calculated and negotiated capitated rates.

OMPP has reported that within the fee-for-service program, the physicians' claims as well as the associated hospital emergency department claims are reimbursed. The fiscal impact of this provision will depend on MCO policy decisions and actions taken to control inappropriate use of emergency departments by their enrollees.

Standardization of MCO Credentialing and Claims Processing: The bill requires that the Medicaid MCOs adopt uniform definitions for certain terms, uniform claims processing, a uniform prescription drug formulary, certain uniform forms to be developed by OMPP, and a one-time Medicaid provider credentialing process. Changes in administrative claims processing, credentialing, and drug purchasing operations within the MCOs would involve costs that would either be covered within the existing contracts to be passed on within annually renegotiated rates or may require OMPP to procure new contracts. The bill requires OMPP to develop three specific forms and to require the MCOs to use the forms. OMPP should be capable of accomplishing forms development within the current level of available resources. MCOs are required to adopt a uniform prescription drug formulary before January 1, 2010.

The bill provides that if the MCOs cannot agree on a uniform formulary, they are to use the Medicaid Drug Utilization Review Board's preferred drug list (PDL). Controlling the cost of prescription drugs through purchasing practices and generic substitution are methods that MCOs use to control costs within the network. The fiscal impact would depend on actions taken by the MCOs to implement this requirement.

Emergency Department Background: This bill provides for physician payments for federally required hospital emergency department screening exams. OMPP reports that federal MCO regulations require the MCOs to pay for screening exams performed on MCO recipients who meet a prudent layperson's definition of what constitutes an emergency condition. Current Indiana statute requires that physicians who are not contracted with the MCO (i.e., out-of-network providers) must be paid at 100% of the Medicaid fee-for-service reimbursement for medically necessary screening services for MCO patients who present at an emergency department with a medical emergency.

This bill would require the payment for all specified screening exams without authorization of the enrollee's primary medical provider. Financially, this requirement would impact the three MCOs differently depending on the contracted status of the emergency department physicians if the organization is currently paying triage fees to contracted providers or denying the claims in total. The fiscal impact of this provision will ultimately depend on actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

The Medicaid managed care program operates under a federally approved waiver. The regulation waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home". The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs, which must be actuarially determined, would be passed through to the state in the negotiated rates for the CY 2010 capitation rate. Any fiscal impact related to this bill would be anticipated to result in higher capitated rates for calendar years 2010 and 2011.

The Medicaid program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

MCO Contract Prescription Drug Requirement: The Family and Social Services Administration (FSSA) has proposed removing the cost of prescription drugs from the capitated rates paid to the MCOs in order to take advantage of the rebates. This bill would eliminate the possibility of removing pharmacy expenditures from the managed care organizations' contracts and the resulting opportunity to maximize the amount of drug rebates that could be claimed by the Medicaid program. An initial estimate of the dollar amount of the rebates that might otherwise be available indicates a potential annual state-only rebate revenue of $22 M.

Background: Within the Medicaid program, pharmacy products are purchased in two ways. In Hoosier Healthwise, the capitated managed care program for pregnant women and children, and the capitated Healthy

Indiana Plan, pharmacy products are included in the capitation rate paid to the MCOs. All other Medicaid pharmacy purchases are purchased on a fee-for-service basis and processed by a contracted pharmacy benefits manager (PBM).

The rebate availability for Medicaid direct purchases means that prescription drugs cost the program more within the capitated HIP and Hoosier Healthwise programs. FSSA has proposed removing the cost of prescription drugs from the capitated rates paid to the MCOs in order to take advantage of the rebates. The current Medicaid PBM would be used to process all drug purchasing.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP.

Local Agencies Affected:

Information Sources: FSSA, Health Finance Commission meeting minutes and attachments, October 22, 2008; Social Security website.

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